

Temporary School Staff Injury Report Instructions

Please use the attached form for any work related injury claims

If you are injured on the job please follow these guide lines:

- 1. Please notify the school and seek medical attention immediately!!
(You can go to any Clinic or hospital for your injuries)**

- 2. Please complete the attached form. Please provide all details regarding the injury.**

- 3. Please include any and all information / documentation pertaining to your injury.**

- 4. Please fax the attached completed form and all documents to,
Temporary School Staff 248-360-9662**

- 5. You will be contacted by Temporary School Staff and / or The Accident Fund Insurance Company regarding your claim.**

Accident Fund Insurance Company of America

232 S. Capital Avenue
P.O Box 40790
Lansing, Michigan 48901-7990
www.accidentfund.com

Claims **FIRST NOTICE OF INJURY FORM**
Website www.accidentfund.com (no log in needed)
Email to: claimsexpress@accidentfund.com
Fax to: (248) 360-9662 (866) 814-5595
Or E-mail to pakdj@sbcgloba.net
Policy # or Fed ID # **WCV 6032483 00 03**

Business Name: **Temporary School Staff**

1. Today's date _____
2. State Injury occurred _____
3. What is the **business name** _____ TEMPORARY SCHOOL STAFF, INC _____
4. Briefly describe the nature of the business _____ PAYROLL FOR SUBSTITUTES IN SCHOOLS DISTRICTS _____
5. What is your name (First & Last) _____ PAMELA KLINK _____
6. What is your title _____ VICE PRESIDENT _____
7. What is your Area code & Phone # _____ 248-360-9544 _____
8. What is the injured **employee's name** _____
9. What is the injured employees date of birth _____ / _____ / _____
10. What is the injured employees home address (include city, state & zip code) _____

11. What is the employee's **home phone #** including area code _____
12. Is the injured employee Male _____ or Female _____
13. What was the date and time of injury _____
14. What is the injured employee's **job title or occupation** _____
If applicable, what is the department / location code? _____
15. What is the full address of the location the injured employee was hired at ?
(city, state & zip code) _____
16. Was the employee **injured at the location listed above** YES _____ NO _____
If (NO), provide the full address where the injury occurred; **provide city, state & zip code**

17. What is the injured employee's **date of hire?** _____
18. What is the employee's hourly rate _____
19. Will the employee be **paid in full** for the day of the injury YES _____ NO _____
20. What time did the injured employee **begin work on the day of injury** _____
21. Will the injured employee **miss time from work** YES _____ NO _____
22. **if yes how many days** _____
23. What was the **last day** the injured employee worked due to the injury _____
24. What date did the injured employee **return to work** or is expected return to work _____
25. What date was the injury **reported to the employer** _____
26. What **type of injury** did the employee sustain? For example contusion, laceration or burn

27. What **body part(s)** was affected _____
28. How did the **accident happen** _____
29. Was the injury **Fatal** YES _____ NO _____ If YES list the date of death _____
30. Did the employee **seek medical treatment** YES _____ NO _____
31. If yes, what **type of medical treatment** did the employee seek
Minor medical treatment by employee / minor medical treatment by clinic / hospital: Emergency care:
Hospitalization for more than 24 hours: or future major medical / lost time anticipated

32. If known, please give name and phone # of **doctor / clinic, employee was treated** _____
33. Is there any additional information that may be pertinent to this claim

34. What is your email address _____

**Fax a copy to both locations: Temporary School Staff (248)360-9662
Accident Fund Insurance Company of America (866) 814-5595**